CDI California Department of Insurance

Consumers Guide to

HEALTH INSURANCE

1-800-927-HELP (800-927-4357)
www.insurance.ca.gov
800-482-4TDD (800-482-4833)

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Consumers Guide To Health Insurance

Introduction to Health Insurance

Illness or non-work related injury can be financially devastating, especially when considering the rising cost of health care over the past 20 years. Health insurance can help protect you from large out-of-pocket health care expenses that can accumulate during an acute or chronic illness. If you have a job, your employer may provide group comprehensive major medical coverage. You can also purchase individual comprehensive major medical coverage privately or through an insurance agent or broker who is licensed by the State of California to sell health insurance products.

This guide summarizes the different types of health coverage and provides contact information should you experience a problem with your plan, agent or broker.

Types of Health Insurance and How Health Insurance Works

Health insurance pays for expenses incurred for diagnosis and treatment of covered medical conditions. There are many different types of health insurance plans available in California. If you have a choice, it is important to choose the plan that best fits your specific needs, budget, and lifestyle. Also, make sure that you are aware of the state or federal agency that regulates the type of health care plan you purchase in case you experience questions or problems. Each of the different ways of receiving health care services has advantages and disadvantages. It is in your best interest to become familiar with the different types of health insurance, so you know what may be available to you.

- Indemnity Policies (Traditional Fee-for-Service Insurance)

- Preferred Provider Organizations (PPOs)
- Health Maintenance Organizations (HMOs or Managed Care)
- Self-Insured Health Plans (Single Employer Self-Insured Plans)
- Multiple Employer Welfare Arrangements (MEWAs)

Indemnity Policies (Traditional Fee-for-Service Insurance)

Most indemnity policies allow you to choose any doctor and hospital that you wish when seeking health care services. The hallmark of traditional fee-for-service insurance is choice. You are given the choice of what provider to visit when seeking covered medical services with few geographic limitations. When purchasing an indemnity policy, you may often have a deductible. The deductible is the amount you are required to pay before policy benefits are provided. You may have a choice in the amount of your deductible. Once the deductible has been paid, the remaining charges are reimbursed to you at a specified percentage according to the policy contract. The difference between eligible charges and the percentage paid is called a "co-payment," and is normally your responsibility. The policy or an employee benefit booklet (if your indemnity policy is group coverage) will spell out the terms and conditions of what is covered and what is not covered. Read your policy or benefit booklet before you need health care services and ask your health insurance agent, insurance company, or employer to explain anything that is unclear.

The California Department of Insurance (CDI) regulates indemnity policies. If you have an individual or group health insurance policy that is a traditional fee-for-service policy issued by a CDI licensed health insurance company, then you may contact the CDI for assistance. Since jurisdiction is divided between state and federal agencies, it can be confusing to determine who regulates your health care coverage. The CDI is always available to assist consumers with health care questions or to direct consumers to the correct agency for assistance. Please see the last page of this brochure for the many ways you can contact the CDI.

Important Points to Remember About Indemnity Policies:

- You have the freedom to choose your doctor, specialist, or hospital with few limitations.
- Your options are seldom if ever limited by geographic restrictions.
- You may be responsible for paying a deductible before covered medical benefits are reimbursable.
- You may be required to pay a co-payment for covered medical services.
- You can seek assistance from the CDI for questions regarding any indemnity policy issued by an insurance company admitted in California.

Preferred Provider Organizations (PPOs)

A Preferred Provider Organization (PPO) provides a list of contracted "preferred" providers from which to choose. You receive the highest monetary benefit when you limit your health care services to those providers on the list.

If you go to a doctor or hospital that is not on the preferred provider list (referred to as going "out-of-network"), then the plan covers a smaller percentage of your health care expenses or may cover none of your health care expenses based on the contract wording of the plan. Always check with your PPO or consult your list of preferred providers before you seek health care services to make certain your physician or hospital is a contracting provider (part of the network). Make sure that your doctor refers you to health care providers within your PPO network, if applicable.

PPOs in California may be regulated by either the CDI or the Department of Managed Health Care (DMHC) depending on whether the contract or policy was issued by a licensed insurance company or a managed care company. The California Department of Managed Health Care regulates HMOs and plans issued by Blue Cross of California and Blue Shield of California. The CDI regulates policies issued by insurance companies such as BC Life and Health Insurance Company and Blue Shield of California Life and Health Insurance Company. If you are confused about whom to call regarding a PPO problem or concern, then consult your plan documents for regulatory information.

Important Points to Remember About Preferred Provider Organizations:

- You receive the highest monetary benefit when staying within the PPO network.
- You may have the option to go outside the PPO network at a higher monetary cost to you.
- Check to make sure your doctor or any specialist referred to you is part of the PPO network before utilizing covered services.

- PPOs can be regulated by either the CDI or the DMHC depending on if the company that issued the contract is a licensed insurance company, or a managed care plan. PPOs can also be self-funded. If you need assistance and you are not sure which agency regulates your plan you can contact the CDI or the DMHC for clarification.

Health Maintenance Organizations (HMOs or Managed Care)

Membership in a Health Maintenance Organization (HMO) requires plan members to obtain their health care services from doctors and hospitals affiliated with the HMO. It is common practice in HMOs for the plan member to choose a primary care physician who treats and directs health care decisions and who coordinates referrals to specialties within the HMO network. The doctors and hospital personnel may be employees of the HMO or contracted providers. Since HMOs operate in restricted geographic regions, this may limit coverage for plan members if medical treatment is obtained outside the HMO network or coverage area. California HMOs are required to cover medically necessary emergency services even when outside of their coverage area. The intent of managed care products is to create less costly delivery of health care services while maintaining quality health care. HMOs offer access to a comprehensive package of covered health care services in return for a prepaid monthly amount (premium). Most HMOs charge a small co-payment depending upon the type of service provided.

All HMOs in California are regulated by the Department of Managed Health Care (DMHC). If you have a complaint with an HMO, contact the member services department of your HMO. HMOs are required to have an internal complaint/grievance process in place. If you file a grievance and it has not been resolved within 30 days or there is some question as to the HMOs decision, then you may contact

the DMHC for assistance. Please see contact information listed for the DMHC in the "Resources" section of this brochure.

Important Points to Remember About Health Maintenance Organizations:

- You must obtain health care services from HMO providers, except in certain emergency situations.
- Your choice of primary care physician is important because he/she directs your care. Also, your primary care physician often coordinates referrals to specialties within the HMO.
- Your options may be limited by the geographic restrictions of the HMO network.
- You may be charged a small co-payment each time you utilize an HMO covered service.
- You can seek assistance from the DMHC on all HMO and managed care questions.

Self-Insured Health Plans (Single Employer Self-Insured Plans)

Self-Insured Health Plans have gained in popularity among large employers, labor unions, school districts and other municipalities. These groups provide a pool of money and then proceed to pay for the health care services of their members (employees) from this pool. It is common for self-insured plans to turn over the administration of their health plans to a Third Party Administrator (TPA). The TPA handles all administrative tasks including claims processing and payments. Often the employer will contract with an insurance company to act as a TPA for all health care claims.

Most self-insured health plans fall under the Employee Retirement Income Security Act (ERISA). ERISA is federal law that is enforced by the U.S. Department of Labor, Employee Benefits Security Administration (DOL-EBSA). If you are a member of a self-insured health plan through your employer or union, then you can contact the DOL-EBSA for assistance. However, the DOL-EBSA does not regulate self-insured health plans that are sponsored through school districts, other municipalities, and churches. If you are a member of this type of plan, you can file a complaint with the plan directly or you may seek a legal remedy through a court of law. The DOL-EBSA is available to answer questions about self-insured employer plans that come under ERISA regulation. You can gain information on the type of plan that you participate in by contacting your employer or union. If there is still some question, then you can contact the DOL-EBSA for clarification. Please see the "Resources" section of this brochure.

Important Points to Remember About Self-Insured Health Plans:

- If you work for a large employer, have a union affiliation, work for a school district, or work for a municipality, the health plan offered to you may be a self-insured entity.
- An insurance company or a TPA may administrate a self-insured health plan.
- Self-Insured health plans are most likely subject to federal ERISA law.
- If your self-insured health plan is not a school district, other municipality, or a church, you can seek help from the DOL-EBSA.
- If your self-insured health plan is a school district, other municipality, or a church, you may seek assistance from the plan directly or from the courts.

Multiple Employer Welfare Arrangements (MEWAs)

MEWAs permit employer members of trade, industry, professional, and other associations to create trust funds for the purpose of offering and providing health care benefits to their employees. Because of significant and widely publicized mishandling of claims by MEWAs in the 1980s and early 1990s, legislation was passed to more closely regulate MEWAs. This legislation forced all MEWAs to file applications for certificates of compliance by November 30, 1995, or cease operating in California. Only MEWAs that satisfied strict requirements were granted certificates of compliance. It is now illegal for new MEWAs to form and to offer health care benefits. Currently, fewer than ten MEWAs have been issued certificates of compliance by the CDI, which permit them to operate legally in California. If your employer presents a health plan to you involving a new MEWA, then contact the CDI immediately. If you receive your health care benefits through one of the approved MEWAs, then you may seek assistance from the CDI if you have any questions or complaints. Please see the last page of this brochure for complete CDI contact information.

Important Points to Remember About Multiple Employer Welfare Arrangements:

- Your employer may offer a MEWA health plan if they are an employer member of a trade, industry, professional, or other association.
- There are currently less than ten MEWAs operating with CDI certificates of compliance.
- After November 30, 1995, no new MEWAs can form, operate, or apply for CDI certificates of compliance.
- You can contact the CDI for any questions regarding MEWAs.

How Is Health Insurance Marketed in California?

Health insurance coverage is sold to consumers through individual policies or group policies. Individual health insurance coverage should be pursued when your employer does not offer health insurance as a benefit of employment, when you cannot be named as the dependent on another person's insurance policy, or when you are not a member of a professional or trade association that offers group coverage. Many consumers are self-employed, contract employees, or work for small employers and do not have access to a group policy secured by an employer. Individual coverage can be obtained by contacting a licensed health insurance agent or broker. You will need to complete an application that includes your medical history, which will be reviewed by a medical underwriter at the health insurance company. If you meet the underwriting qualifications and are issued a policy, the company may not cover preexisting conditions up to one year after the effective date of the policy. However, if you have been previously insured under an individual or group policy without a break in coverage of more than 62 days, your new insurance company must apply the prior creditable coverage (refer to the "Health Insurance Terms" on page 25) towards any waiting period for preexisting conditions. Individual health insurance companies may reject your application based on your medical history.

Group health insurance offers certain advantages over individual health insurance policies. The waiting period for preexisting conditions is six months for policies covering 3 or more persons, not one year as with individual policies. Also, if you have been previously insured under a group policy without a break in coverage of more than 180 days, your new insurance company must apply the prior creditable coverage toward the six-month waiting period for preexisting conditions. It should be noted that, upon application for

coverage, large employer groups (more than 50 employees) may be underwritten, as a group, by insurance companies. However, after coverage becomes effective, newly hired employees entering the group health plan must be afforded coverage without going through the medical underwriting process. Association group health insurance, like individual health insurance, is subject to medical underwriting. You can be denied coverage based on your medical history. Medical underwriting rules for small group health insurance (2-50 employees) differs from large group and individual health insurance policies. Regardless of any preexisting condition, you must be offered coverage under a small group policy on a guaranteed issue basis. However, the small group insurance company can utilize the six-month waiting period for preexisting conditions. Of course, if you have prior creditable coverage it must be applied to decrease or eliminate the waiting period.

Important Points to Remember About Individual and Group Health Insurance Coverage:

- Health insurance coverage is sold to consumers under either individual or group policies.
- Individual and Association group policies are subject to medical underwriting, on an individual basis.
- Qualifying creditable coverage must be applied towards the year waiting period for preexisting conditions in individual policies and towards the six-month waiting period for preexisting conditions in group policies.
- Small group policies require that coverage be offered on a guaranteed issue basis regardless of any preexisting condition.

What Is COBRA and Cal-COBRA?

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is federal law that extends your current group health insurance when you experience a qualifying event such as termination of employment or reduction of hours to part-time status. The extension period is 18 months and some people with special qualifying events may be eligible for a longer extension. To be eligible for COBRA, your group policy must be in force with 20 or more employees covered on more than 50 percent of its typical business days in the previous calendar year.

Indemnity policies, PPOs, HMOs, and self-insured plans are all eligible for COBRA extension; however, federal government employee plans and church plans are exempt from COBRA. Individual health insurance is also exempt from COBRA extension, which may be another reason to pursue participation in group health plans, if possible.

Cal-COBRA is a California law that has similar provisions to federal COBRA. With Cal-COBRA the group policy must be in force with 2-19 employees covered on at least 50 percent of its working days during

- the preceding calendar year, or,
- the preceding calendar quarter, if the employer was not in business during any part of the preceding calendar year.

Eligibility for Cal-COBRA extends to indemnity policies, PPOs, and HMOs only. Self-insured plans are not eligible. Unlike COBRA, church plans are eligible under Cal-COBRA. It is important to note that both COBRA and Cal-COBRA do not apply to individual health insurance.

As of January 1, 2003, the extension period for Cal-COBRA has been changed from 18 months to 36 months. If you become eligible for Cal-COBRA after January 1, 2003, you will have the benefit of Cal-COBRA coverage for a full 36 months instead of the prior 18-month coverage extension. California Insurance Code (CIC) Section 10128.59 provides a similar extension under Cal-COBRA for those who have exhausted their 18 months on federal COBRA (or longer in special circumstances) for a total extension that cannot exceed 36 months. For the special Cal-COBRA extension to apply, you must have become eligible for COBRA after January 1, 2003, and the employer's master policy must be issued in California. If the group master policy is not issued in California, then the employer must employ 51% or more of its employees in California and have its principal place of business in California for their California employees to take advantage of Cal-COBRA.

COBRA is regulated by the DOL-EBSA, and Cal-COBRA is jointly regulated by the CDI and the DMHC depending upon what type of group coverage you have (indemnity or HMO). These agencies can provide further information on the time frames employers and insurance companies/health plans must follow to offer COBRA or Cal-COBRA extension coverage for eligible employees and their dependents. Also, information can be furnished on the actions and responsibilities required by employees to participate and elect continuation of benefits under COBRA or Cal-COBRA. When experiencing questions or problems with COBRA or Cal-COBRA, you can reach the appropriate state or federal agency by referencing the contact information available in the resources section of this brochure.

Important Points to Remember About COBRA and Cal-COBRA:

- COBRA is federal law that extends your current group health coverage after a qualifying event. Individual policies do not qualify for COBRA.
- COBRA law applies to group policies in force with 20 or more employees covered on more than 50 percent of its typical business days in the previous calendar year.
- Indemnity policies, HMOs, PPOs, and self-insured plans are COBRA eligible. Federal government employee plans and church plans are COBRA exempt.
- Cal-COBRA is California law that closely follows federal COBRA.
- Cal-COBRA law applies to group policies in force with 2-19 employees covered. Like COBRA, individual policies do not qualify for Cal-COBRA.
- Only indemnity policies, PPOs, HMOs, and church plans are Cal-COBRA eligible.
- You can contact the DOL-EBSA for questions regarding COBRA law.
- You can contact either the CDI (on indemnity policies) or the DMHC (on HMO/managed care plans) for questions regarding Cal-COBRA law.

What Is the Health Insurance Portability and Accountability Act (HIPAA)?

In 1996 the federal government passed into law the Health Insurance Portability and Accountability Act (HIPAA). HIPAA law provides eligible individuals who have recently lost their employer sponsored group health plan the opportunity to purchase health insurance coverage even if they have a preexisting health condition. If you meet the definition of an eligible individual, all health insurance companies who sell individual plans must offer you health insurance regardless of your medical history. This requirement to issue insurance is called "guaranteed issue." You may not be declined coverage based on medical reasons. In order to qualify as an eligible individual you must meet the following conditions:

- Your last health care coverage must have been under an employer sponsored group health plan, which includes COBRA or Cal-COBRA continuation coverage, for at least 18 months. This prior 18-month coverage is referred to as "creditable coverage."

- All available COBRA or Cal-COBRA continuation coverage has been elected and exhausted. If you qualify for COBRA or Cal-COBRA you are required to accept the coverage and continue the coverage for the maximum time period allowed. (When an employer terminates its existing group health plan entirely, COBRA or Cal-COBRA coverage ends and is considered exhausted.)

- You are not eligible under a group health plan, Medicare, Medi-Cal, and/or do not have other health insurance coverage.

- You did not lose your most recent health coverage due to nonpayment of premium or fraud.

Once COBRA or Cal-COBRA has been exhausted, you have 63 days to file an application to purchase a guaranteed issue HIPAA policy with an insurance company or health plan. All carriers that sell individual health care policies must offer their two most marketed individual plans to HIPAA eligible individuals regardless of your health status. If you accept a conversion policy or a short-term policy after exhausting COBRA or Cal-COBRA, you give up your HIPAA eligibility. It is important to understand that a conversion policy is not a HIPAA policy.

When applying for a HIPAA policy you can present a Certificate of Creditable Coverage from your insurance company or health plan as part of the application process. The Certificate of Creditable Coverage is a written statement from your insurance company or health plan showing the length of time you have been covered. The Certificate can be used as proof of your 18 months continuous creditable coverage when applying for a HIPAA policy.

Although HIPAA is federal law, as of January 1, 2001, California state law generally conforms with HIPAA. Depending on the type of coverage you have (indemnity or HMO), you can contact either the CDI or the DMHC if you are experiencing problems securing a HIPAA policy. Please see the contact information in the resources section of this brochure to reach the CDI or DMHC regarding HIPAA questions.

Important Points to Remember About HIPAA:

- HIPAA gives eligible individuals who have lost group coverage the opportunity to purchase individual health coverage.
- HIPAA eligible individuals are not subject to medical underwriting.
- HIPAA policies must be issued to eligible individuals on a guaranteed issue basis regardless of any preexisting medical condition.
- You have only 63 days after COBRA or Cal-COBRA has been exhausted to file an application to purchase a HIPAA policy.
- HIPAA policies are not conversion policies. Accepting a conversion or short-term policy terminates your HIPAA eligibility.
- You may contact the CDI or the DMHC depending on the type of coverage you have (indemnity or HMO) if you are experiencing problems with HIPAA.

Consumer Inquiries and Complaints

If you have a health insurance inquiry or you are experiencing a problem with your insurance company or agent, the California Department of Insurance (CDI) stands ready to assist you.

If you would like to inquire about a general health insurance issue or file a complaint you may do so by contacting our Consumer toll free number 1-800-927-4357. Inquiries and complaints can also be submitted electronically via our website at: www.insurance.ca.gov.

Before filing a complaint with the CDI, you should first contact the insurance company, agent or broker in an effort to resolve the issue. If you do not receive a satisfactory response, you can file a complaint with the CDI.

To file a complaint you will need to complete a "Request for Assistance" (RFA). You can obtain an RFA by contacting our consumer toll free number 1-800-927-4357 or by visiting our website at www.insurance.ca.gov and clicking on CONSUMERS.

State Sponsored or Administered Health Coverage

The state of California offers specialty programs and/or assistance programs to those who do not qualify for health insurance due to preexisting conditions or income restrictions, and for small employers of 2 to 50 workers. Contact information for each of the programs is available in the resources section of this brochure.

Major Risk Medical Insurance Program (MRMIP)

The Major Risk Medical Insurance Program (MRMIP) offers limited health insurance benefits to California residents who are unable to purchase health insurance due to a preexisting medical condition. If you have a preexisting condition and are not eligible for COBRA, Cal-COBRA, or HIPAA, then you can apply to MRMIP as a last resort to obtain health coverage. This program provides health care coverage through contracted health insurance companies and health plans. MRMIP is partially subsidized; however, qualifying participants must pay a portion of the premium, which can be costly. MRMIP is under the jurisdiction of the Managed Risk Medical Insurance Board (MRMIB).

As a result of California legislation there is a 36-month limit for participation in MRMIP. At the end of this period, MRMIP enrollees are given a one-time opportunity to purchase guaranteed issue health coverage through any indemnity policy, PPO, or HMO currently offering individual health coverage in California. Eligible MRMIP participants who are "disenrolling" after the 36-month period have 63 days to apply for individual health coverage. Ninety days prior to the disenrollment, MRMIP participants receive a notice of disenrollment and 45 days prior to disenrollment, participants are mailed a Certificate of Program Completion that enables them to obtain individual health coverage.

All indemnity insurance companies, PPOs, and HMOs who offer comprehensive individual medical coverage in California are required to offer a Standard Benefit Plan that is substantially the same as the health coverage offered while on MRMIP. These Standard Benefit Plans are the only health coverage required to be offered on a guaranteed issue basis and are separate from other individual health coverage that is available in the marketplace. If you have questions on the Standard Benefit Plans that are being offered, contact the CDI or the DMHC depending upon the type of individual coverage you want to elect (indemnity or HMO).

Healthy Families Program

Originally designed to protect children of low income parents, the Healthy Families Program provides low cost health, dental, and vision coverage to children whose parents earn too much to qualify for public assistance, but do not earn enough to purchase comprehensive major medical coverage for their children. The Healthy Families Program is administered by MRMIP. There is a current proposal to expand the Healthy Families Program to include the parents of eligible children through special federal funding.

Access for Infants and Mothers Program (AIM)

In an effort to expand prenatal and preventive care for pregnant women, California established the Access for Infants and Mothers Program (AIM). AIM is administered by a five-person board that has established a comprehensive benefits package that includes both inpatient and outpatient care for program enrollees. Pregnant women of low to moderate income are eligible for the program and participate in the cost of health care services by paying a reduced premium. The state of California subsidizes AIM to make up for the full cost of the program benefits.

Supplemental Health Insurance Policies

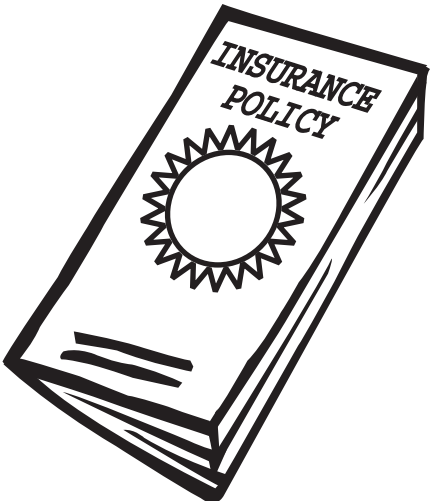
Most supplemental health insurance policies are designed to pay in addition to your comprehensive major medical coverage. These supplemental policies should not be used as a substitute or replacement for a traditional health insurance policy or a health plan. Supplemental health insurance can pay limited benefits such as a daily dollar amount if you are hospitalized (hospital income policy) or a lump sum dollar amount if you are diagnosed with a specified or named disease, such as cancer. This type of supplemental policy can also be structured to pay expenses incurred in the treatment of the specified disease. Sometimes this insurance provides payment over and above your medical expenses. It is important that you understand the limitations and exclusions of supplemental health insurance policies and how the policies coordinate benefits, so that you can make the best decision based on your needs and your budget.

Resources

Access for Infants and Mothers Program (AIM)
P.O. Box 15248
Los Angeles, CA 90015
Phone: 800-433-2611
Web site: www.mrmib.ca.gov/MRMIB/AIM.html

California Association of Health Underwriters (CAHU)
P.O. Box 1071
Fresno, CA 93714
Phone: 800-322-5934
Web site: www.cahu.org

U. S. Department of Labor
Employee Benefits Security Administration (DOL-EBSA)
Southern California
1055 E. Colorado Blvd., Suite 200
Pasadena, CA 91106-2341
Phone: 626-229-1000
Phone: 866-444-3272



Northern California
71 Stevenson Street, Suite 915
San Francisco, CA 94105
Phone: 415-975-4600
Phone: 866-444-3272
Web site: www.dol.gov/ebsa

Department of Managed Health Care (DMHC)
980 Ninth Street, Suite 500
Sacramento, CA 95814-2725
Phone: 888-466-2219
Web site: www.dmhc.ca.gov

Healthy Families Program
P.O. Box 138005
Sacramento, CA 95813-8005
Phone: 800-880-5305
Web site: www.healthyfamilies.ca.gov

Managed Risk Medical Insurance Program (MRMIP)
P.O. Box 9044
Oxnard, CA 93031-9044
Phone: 800-289-6574
Web site: www.mrmib.ca.gov

Health Insurance Terms

Assignment of Benefits — Your signed authorization to your doctor or hospital (medical provider) assigning payment to be made directly to them for your medical treatment.

Business Day — Every day an insurance company is open for business, which excludes Saturday, Sunday, and state and federal holidays.

Calendar Day — Every day of the calendar month, which includes Saturday, Sunday, and state and federal holidays. However, if any action tied to a time frame in an insurance policy or CDI regulation or code falls on a Saturday, Sunday, or state or federal holiday; then the action is postponed to the next calendar day that does not fall on a Saturday, Sunday, or state or federal holiday.

Certificate of Coverage — A document issued to a member of a group health insurance plan showing evidence of participation in the insurance.

Certificate of Creditable Coverage — A written statement from your prior insurance company or health plan documenting the length of time you were covered.

Creditable Coverage or Prior Qualifying Coverage — The number of months you had health insurance in place before your current or new policy became effective. Creditable coverage must be counted towards any preexisting condition exclusion in either an individual or group policy.

Claim — A notification to your insurance company that payment is due under the policy provisions.

Co-payment — The portion of charges you pay to your provider for covered health care services in addition to any deductible.

Coverage — The scope of protection provided by an insurance contract which includes any of the listed benefits in an insurance policy.

Denial — An insurance company decision to withhold a claim payment or preauthorization. A denial may be made because the medical service is not covered, not medically necessary, or experimental or investigational.

Deductible — A fixed amount which is deducted from eligible expenses before benefits from the insurance company are payable.

ERISA — Stands for the Employee Retirement Income Security Act (1974). Administered by the U.S. Department of Labor, Employee Benefits Security Administration. ERISA regulates employer sponsored pension and insurance plans (self-insured plans) for employees.

Exclusions and/or Limitations — Conditions or circumstances spelled out in an insurance policy which limit or exclude coverage benefits. It is important to read all exclusion, limitation, and reduction clauses in your health insurance policy or certificate of coverage to determine which expenses are not covered.

Experimental and/or Investigational Medical Services — A drug, device, procedure, treatment plan, or other therapy which is currently not within the accepted standards of medical care.

Grace Period — A specified period immediately following the premium due date during which a payment can be made to continue a policy in force without interruption. This applies only to Life and Health policies. Check your policy to be sure that a grace period is offered and how many days, if any, are allowed.

Guaranteed Issue — A health insurance policy that must be issued regardless of any preexisting medical condition. The present and past physical condition of a health insurance applicant is not considered as a part of underwriting. No physical examination is required. The insurance company cannot decline coverage to an applicant of a guaranteed issue policy based on medical history.

Independent Medical Review — A process where expert medical professionals who have no relationship to your health insurance company or health plan review specific medical decisions made by the insurance company. California law provides for an Independent Medical Review Program, which is administered by the CDI and the DMHC depending upon what type of coverage you have (indemnity or HMO).

Medically Necessary — A drug, device, procedure, treatment plan, or other therapy that is covered under your health insurance policy and that your doctor, hospital, or provider has determined essential for your medical well-being, specific illness, or underlying condition.

Policy — The written contract between an individual or group policyholder and an insurance company. The policy outlines the duties, obligations, and responsibilities of both the policyholder and the insurance company. A policy may include any application, endorsement, certificate, or any other document that can describe, limit, or exclude coverage benefits under the policy.

Preexisting Condition — Any illness or health condition for which you have received medical advice or treatment during the six months prior to obtaining health insurance. Group healthcare policies of 3 or more persons cover preexisting

conditions after you have been insured for 6 months, and individual policies cover preexisting conditions after you have been insured for 1 year. Creditable coverage must be counted towards any preexisting condition exclusion in either an individual or group policy.

Usual, Reasonable, and Customary — The amount that your insurance company determines is the normal payment range for a specific medical procedure performed within a given geographic area. If the charges you submit to your health insurance company are higher than what is considered normal for the covered health care services, then your health insurance company may not allow the full amount charged to you.

Talk to us

Do you have a question, comment or concern?
There are several ways to talk to us:

- Call our Consumer Hotline at (800) 927-HELP
- Telecommunication Device for the Deaf dial (800) 482-4TDD
- Telephone lines are open 8:00 AM to 6:00 PM Pacific Time, Monday through Friday, excluding holidays

- Write: California Department of Insurance
  300 South Spring St., South Tower
  Los Angeles, CA 90013

- E-mail us through our Web site at: www.insurance.ca.gov

- Visit us in person on the 9th Floor at the address above. Office Hours: Monday through Friday 8:00 AM to 5:00 PM Pacific Time, excluding holidays.